

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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MEDICAID BULLETIN

CLTC
DME

TO: DURABLE MEDICAL EQUIPMENT (DME) PROVIDERS

SUBJECT:

- I. Reimbursement Policy Updates, Deletions, Changes**
- II. Coverage Criteria for Hospital Bed, Semi-Electric (E0260)**
- III. Coverage Criteria for Use of External Insulin Pump (E0784) and Related Supplies**
- IV. Revised Medicaid Certificate Of Medical Necessity (MCMN) Form**
- V. Policy Clarifications for Documentation, Diabetic Strips and Web-based Claims Status Check**
- VI. Changes and Clarifications of Policies Concerning Waiver Services**

I. Reimbursement Policy Updates, Deletions and Changes

This Medicaid Bulletin details the changes to the Durable Medical Equipment (DME) reimbursement system that have been implemented effective for the dates of service beginning October 1, 2008. These changes are in accordance with the actions indicated in the Medicaid Bulletin of September 10, 2008, regarding Budget Reductions. This bulletin includes detailed information concerning covered code changes by South Carolina Department of Health and Human Services (SCDHHS), certain DME policy changes, and discontinued codes as indicated.

The following codes have been discontinued:

A1231	A4255	A4321	A4335	A4379	A4396	A4418	A4421	A4455	A4608	A4619
A4636	A5082	A5126	A6198	A6217	A6256	A6450	A6451	A6513	A7028	A7029
A7523	A7524	A9900	B4083	B4102	B4176	E0198	E0200	E0256	E0273	E0290
E0292	E0293	E0606	E0641	E0642	E0650	E0744	E0849	E0941	E0969	E1003
E1004	E1006	E1009	E1011	E1016	E1030	E1240	E1270	E2216	E2217	E2225
E2313	E2323	E2324	E2327	E2328	E2329	E2351	E2506	E2508	K0010	K0012
K0098	K0826	K0838	K0839	K0840	K0854	K0855	K0891	L0112	L0170	L0452
L0458	L0464	L0488	L0622	L0635	L0710	L0830	L0861	L0982	L1025	L1100
L1250	L1270	L1499	L1520	L1630	L1650	L1660	L1680	L1700	L1710	L1840
L1910	L1920	L2010	L2070	L2080	L2090	L2128	L2132	L2136	L2240	L2370
L2375	L2380	L2580	L2670	L3465	L3470	L3520	L3595	L3649	L3764	L3935
L3964	L3970	L3973	L3974	L3984	L4040	L4100	L5060	L5200	L5220	L5230

L5270	L5280	L5311	L5331	L5500	L5510	L5570	L5585	L5590	L5626	L5628
L5638	L5639	L5643	L5661	L5672	L5677	L5686	L5699	L5702	L5712	L5728
L5795	L5818	L5855	L5856	L5857	L5858	L5960	L5968	L5971	L5999	L6025
L6100	L6250	L6400	L6500	L6600	L6623	L6632	L6635	L6646	L6676	L6684
L6895	L6920	L6925	L6930	L6935	L6940	L6945	L6950	L6955	L6960	L6965
L6970	L6975	L7007	L7008	L7009	L7040	L7045	L7170	L7180	L7181	L7185
L7186	L7190	L7191	L7260	L7261	L7266	L7272	L7274	L7360	L7362	L7364
L7366	L7368	L7401	L7404	L7499	L7600	L8300	L8330	L8499	L8514	L9900
S9353	S9497	S9559	S9560	V2626						

The following codes have been added: A4280, K0606, L0140, L0210, L0972, 2035, L3807, L3808, L5845, L5985, L6687, L8623, L8624.

II. Coverage Criteria for Hospital Bed, Semi-Electric (E0260)

Medicaid covers most hospital beds. As is customary, each request is handled on a case-by-case basis. In order for a patient to be eligible to receive a hospital bed, the patient's condition must make such an item medically necessary. A physician's prescription, Medicaid Certificate of Medical Necessity (MCNN) and additional documentation, including medical records and physician's reports, must establish medical need. In appropriately documented cases, Medicaid may determine that a hospital bed is medically necessary and, therefore, covered for the following situations:

- Patients who require positioning of the body to alleviate pain, promote good body alignment, prevent contractors, avoid respiratory infections, etc., in ways not feasible in an ordinary bed.
- Patients with severe arthritis and other injuries to lower extremities, e.g., fractured hip such that the patient requires the variable height feature to assist him/her to ambulate by enabling the patient to place his or her feet on the floor while sitting on the edge of the bed.
- Patients with severe cardiac conditions who are able to leave bed, but who must avoid the strain of "jumping" up or down.
- Patients with spinal cord injuries, including quadriplegic and paraplegic patients and multiple limb amputees. For those patients who are able to transfer from bed to a wheelchair, with or without help.
- Patients with other severely debilitating diseases and conditions, if the variable height feature is required to assist the patient to ambulate.

If the stated reason for a hospital bed is the patient's positioning, the prescription or other documentation must describe the medical condition and also the severity and frequency of the symptoms of the condition that necessitate a hospital bed for positioning.

If the stated reason for a hospital bed is that the patient's condition requires special attachments, the prescription must describe the patient's condition and specify the attachments that require a hospital bed. Special attachments will only be considered if they cannot be fixed or used on an ordinary bed. Bedside rails can be covered when an integral part of, or an accessory to, a hospital bed.

Requests for bariatric beds for patients who are morbidly obese must include information regarding weight management. A hospital bed will not be approved for morbid obesity alone.

Electric powered adjustments to lower and raise the head and foot of the bed may be covered when:

1. Medicaid determines that the patient's condition requires a frequent change in body position;
2. And/or there may be an immediate need for a change in body position;
3. And the patient can operate the controls and cause the adjustments. Exceptions may be made in cases of spinal cord injury and brain damaged patients. The documentation must indicate that the patient/caretaker can perform these changes in body positioning only by use of electric controls.

III. Coverage Criteria for External Insulin Pump (E0784) and Related Supplies

Continuous subcutaneous insulin infusion and related supplies are covered as medically necessary for the treatment of:

- Gestational diabetes; OR
- Insulin dependent Diabetes Mellitus for beneficiaries meeting all requirements listed below:

For initial approval, the following information must be included on the MCMN form or attached documentation:

1. The beneficiary has a diagnosis of insulin dependent diabetes mellitus or gestational diabetes.
2. An endocrinologist, physician, physician assistant, or nurse practitioner experienced in pump therapy orders the insulin pump and monitors the beneficiary's status at least every three months during the period of time that the beneficiary uses the pump.
3. The physician, physician assistant, or nurse practitioner documents a history of poor glycemic control on multiple daily injections of insulin, including a persistently elevated glycosylated hemoglobin level (HbA1C>7.0%).
4. The physician, physician assistant, or nurse practitioner documents additional history of poor control, such as:
 - widely fluctuating blood glucose levels before bedtime or mealtime; or
 - history of severe hypoglycemia (<60 mg/dL) or hyperglycemia(>300 mg/dL); or fasting blood glucose levels frequently above 200mg/dL; or
 - treatment of secondary diabetic complications requiring tighter blood glucose control.
5. The physician, physician assistant, or nurse practitioner documents that the beneficiary and/or caregiver has demonstrated the ability and commitment to comply with the regimen of pump care, frequent self-monitoring of blood glucose, and careful attention to diet and exercise. For pediatric beneficiaries, the documentation should also address that the caregiver/parent is motivated and committed to use the insulin pump, test the child's blood glucose, and return for follow-up appointments as ordered. The beneficiary has been receiving at least three subcutaneous insulin injections per day for a minimum of six months prior to initiation of the insulin pump.

6. The beneficiary has been self-monitoring blood glucose averaging four times per day for a minimum of one month prior to initiation of the insulin pump.

IV. Revised MCMN Form

Changes to the revised MCMN Form(s) can be found on the SCDHHS website:
<http://www.dhhs.state.sc.us/internet/pdf/manuals/dme/Forms.pdf>

V. Policy Clarifications for Documentation, Diabetic Strips and Web-Based Claims Status Check

A. Documentation

The following documentation must be submitted when requesting a Prior Authorization (PA)

1. Completed PA Form (if faxed, must be legible).
2. Completed MCMN form and original prescription (if faxed must be legible).
3. PT/OT evaluation for all mobility devices.

DME will reimburse for medically necessary items only. Items billed as convenience or prevention will not be covered. Additional medical documentation may be requested by DME staff to ensure medical necessity is established. This may be requested on a case-by-case basis.

B. Diabetic Strips

Eligible Medicaid beneficiaries under the age of 21 can receive up to 300 diabetic strips per month as needed; those age 21 and over can receive up to 150 diabetic strips per month. If additional diabetic strips are needed, then the treating/ordering physician, nurse practitioner, or physician assistant must justify the medical need for the specific number of additional diabetic strips on the MCNN form.

C. Web-based Claims Status Check.

SCDHHS provides a free tool, accessible through an Internet browser, which allows providers to submit CMS-1500 claims, query Medicaid eligibility, and check claim status. Providers must use the **Web-based tool to check claim status**. You must complete a Trading Partner Agreement (TPA) with SCDHHS. Once SCDHHS receives the TPA form, the provider will be contacted with the Web site address and login information. For information on this tool or to receive a TPA form, please contact the South Carolina Medicaid Electronic Data Interchange Support Center at 1-888-289-0709.

VI. Changes and Clarifications of Policies Concerning Waiver Services

Changes to Reimbursement Rates for Incontinence Supplies for Participants in Home and Community Based Waiver Programs:

Community Long Term Care (CLTC) and the Department of Disabilities and Special Needs (DDSN) authorize incontinence supplies for waiver participants. Effective with dates of service on or after October 1, 2008, a 3% reduction in the reimbursement rates on incontinence supplies was implemented for all incontinence supplies billed for waiver participants. Participants in the Community Choices, HIV/AIDS and Vent Waivers will continue to receive 96 diapers, 80 briefs or 130 incontinence pads and one case of under pads and one box of wipes as frequently as once per month as authorized by CLTC.

Participants in the Mentally Retarded/Related Disability and Head and Spinal Cord Waiver will continue to receive up to three cases of incontinence supplies per month. For detailed coding and pricing information, please reference the waiver section of your DME manual which can be found on the SCDHHS website

<http://www.dhhs.state.sc.us/internet/pdf/manuals/dme/SECTION%202.pdf>.

The following chart will be inserted on pages 2-20 and 2-22 of the SCDHHS DME manual replacing the previous chart.

DDSN Incontinence Supplies

Diaper Size	Diaper Price	Maximum Frequency	Case Quantity Authorized	Procedure Code	Total Reimbursement
Adult Extra Large	\$1.26/diaper	3 cases Monthly	54	T4524	\$68.04
Adult Large	\$0.97/diaper	3 cases Monthly	72	T4523	\$69.84
Adult Medium	\$0.73/diaper	3 cases Monthly	96	T4522	\$70.08
Adult Small	\$0.73/diaper	3 cases Monthly	96	T4521	\$70.08
Youth Diaper	\$0.73/diaper	3 cases Monthly	96	T4533	\$70.08
Child Small/Medium	\$0.73/diaper	3 cases Monthly	96	T4529	\$70.08
Child Large	\$0.73/diaper	3 cases Monthly	96	T4530	\$70.08
Under Pads	\$45.00/case	3 cases Monthly	1	A4554	\$43.65

The following chart will be inserted on pages 2-23, 2-24 and 2-25 of the SCDHHS DME manual and replaces the previous chart.

CLTC Incontinence Supplies

Service	Rate	Maximum Frequency	Quantity Authorized	Procedure Code	Total Reimbursement
Adult Extra Large	\$1.26/diaper	Monthly	96	T4524	\$120.96
Adult Large	\$0.97/diaper	Monthly	96	T4523	\$93.12
Adult Medium	\$0.73/diaper	Monthly	96	T4522	\$70.08
Adult Small	\$0.73/diaper	Monthly	96	T4521	\$70.08
Youth Diaper	\$0.73/diaper	Monthly	96	T4533	\$70.08
Adult Brief Extra Large (protective underwear)	\$1.26/brief	Monthly	80	T4528	\$100.08
Adult Brief Large (protective underwear)	\$0.97/brief	Monthly	80	T4527	\$77.60
Adult Brief Medium (protective underwear)	\$0.87/brief	Monthly	80	T4526	\$69.60
Adult Brief Small (protective underwear)	\$0.87/brief	Monthly	80	T4525	\$69.60
Youth Brief (protective underwear)	\$0.87/brief	Monthly	80	T4534	\$69.60
Incontinence Pads	\$0.29/pad	Monthly	130	T4535	\$37.70
Under Pads	\$43.65/case	Monthly	1	A4554	\$43.65
Wipes	\$7.76/box	Monthly	70	T5999	\$7.76

Questions regarding this bulletin should be directed to the Department of Durable Medical Equipment at 1-803-898-2882.

/s/

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Director

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Note: To sign up for Electronic Funds Transfer of your Medicaid payment, please go to <http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp> and select "Electronic Funds Transfer (EFT)" for instructions.